

Senate Study Bill 1009

SENATE FILE _____
BY (PROPOSED COMMITTEE ON
COMMERCE BILL BY
CHAIRPERSON ANGELO)

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

1 An Act relating to the required provider provisions under group
2 health insurance policies and health maintenance organization
3 contracts.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
5 TLSB 1798SC 80
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1 1 Section 1. Section 509.3, subsections 5, 6, and 7, Code
1 2 2003, are amended to read as follows:
1 3 5. A provision shall be made available to policyholders,
1 4 under group policies covering vision care services or
1 5 procedures, for payment of necessary medical or surgical care
1 6 and treatment provided by an optometrist licensed under
1 7 chapter 154 if the care and treatment are provided within the
1 8 scope of the optometrist's license and if the policy would pay
1 9 for the care and treatment if the care and treatment were
1 10 provided by a person engaged in the practice of medicine or
1 11 surgery as licensed under chapter 148 or 150A. The provision
1 12 shall also guarantee that any care or treatment provided by an
1 13 optometrist shall be compensated at the same level as
1 14 equivalent services provided by a person licensed in the
1 15 practice of medicine and surgery under chapter 148 or 150A.
1 16 The policy shall provide that the policyholder may reject the
1 17 coverage or provision if the coverage or provision for
1 18 services which may be provided by an optometrist is rejected
1 19 for all providers of similar vision care services as licensed
1 20 under chapter 148, 150A, or 154. This subsection applies to
1 21 group policies delivered or issued for delivery after July 1,
1 22 1983, and to existing group policies on their next anniversary
1 23 or renewal date, or upon expiration of the applicable
1 24 collective bargaining contract, if any, whichever is later.
1 25 This subsection does not apply to blanket, short-term travel,
1 26 accident only, limited or specified disease, or individual or
1 27 group conversion policies, or policies designed only for
1 28 issuance to persons for coverage under Title XVIII of the
1 29 Social Security Act, or any other similar coverage under a
1 30 state or federal government plan.
1 31 6. A provision shall be made available to policyholders
1 32 under group policies covering diagnosis and treatment of human
1 33 ailments for payment or reimbursement for necessary diagnosis
1 34 or treatment provided by a chiropractor licensed under chapter
1 35 151, if the diagnosis or treatment is provided within the
2 1 scope of the chiropractor's license and if the policy would
2 2 pay or reimburse for the diagnosis or treatment by a person
2 3 licensed under chapter 148, 150, or 150A of the human ailment,
2 4 irrespective of and disregarding variances in terminology
2 5 employed by the various licensed professions in describing the
2 6 human ailment or its diagnosis or its treatment. The
2 7 provision shall also guarantee that any care or treatment
2 8 provided by a chiropractor shall be compensated at the same
2 9 level as equivalent services provided by a person licensed in
2 10 the practice of medicine and surgery under chapter 148 or
2 11 150A. The policy shall provide that the policyholder may
2 12 reject the coverage or provision if the coverage or provision
2 13 for diagnosis or treatment of a human ailment by a
2 14 chiropractor is rejected for all providers of diagnosis or
2 15 treatment for similar human ailments licensed under chapter
2 16 148, 150, 150A, or 151. A policy of group health insurance
2 17 may limit or make optional the payment or reimbursement for
2 18 lawful diagnostic or treatment service by all licensees under
2 19 chapters 148, 150, 150A, and 151 on any rational basis which
2 20 is not solely related to the license under or the practices
2 21 authorized by chapter 151 or is not dependent upon a method of

2 22 classification, categorization, or description based directly
2 23 or indirectly upon differences in terminology used by
2 24 different licensees in describing human ailments or their
2 25 diagnosis or treatment. This subsection applies to group
2 26 policies delivered or issued for delivery after July 1, 1986,
2 27 and to existing group policies on their next anniversary or
2 28 renewal date, or upon expiration of the applicable collective
2 29 bargaining contract, if any, whichever is later. This
2 30 subsection does not apply to blanket, short-term travel,
2 31 accident-only, limited or specified disease, or individual or
2 32 group conversion policies, or policies under Title XVIII of
2 33 the Social Security Act, or any other similar coverage under a
2 34 state or federal government plan.

2 35 7. A provision shall be made available to policyholders,
3 1 under group policies covering hospital, medical, or surgical
3 2 expenses, for payment of covered services determined to be
3 3 medically necessary provided by registered nurses certified by
3 4 a national certifying organization, which organization shall
3 5 be identified by the Iowa board of nursing pursuant to rules
3 6 adopted by the board, if the services are within the practice
3 7 of the profession of a registered nurse as that practice is
3 8 defined in section 152.1, under terms and conditions agreed
3 9 upon between the insurer and the policyholder, subject to
3 10 utilization controls. The provision shall also guarantee that
3 11 any care or treatment provided by registered nurses shall be
3 12 compensated at the same level as equivalent services provided
3 13 by a person licensed in the practice of medicine and surgery
3 14 under chapter 148 or 150A. This subsection shall not require
3 15 payment for nursing services provided by a certified nurse
3 16 practicing in a hospital, nursing facility, health care
3 17 institution, physician's office, or other noninstitutional
3 18 setting if the certified nurse is an employee of the hospital,
3 19 nursing facility, health care institution, physician, or other
3 20 health care facility or health care provider. This subsection
3 21 applies to group policies delivered or issued for delivery in
3 22 this state on or after July 1, 1989, and to existing group
3 23 policies on their next anniversary or renewal dates, or upon
3 24 expiration of the applicable collective bargaining contract,
3 25 if any, whichever is later. This subsection does not apply to
3 26 blanket, short-term travel, accident only, limited or
3 27 specified disease, or individual or group conversion policies,
3 28 policies rated on a community basis, or policies designed only
3 29 for issuance to persons for eligible coverage under Title
3 30 XVIII of the federal Social Security Act, or any other similar
3 31 coverage under a state or federal government plan.

3 32 Sec. 2. Section 509.3, Code 2003, is amended by adding the
3 33 following new subsection:

3 34 NEW SUBSECTION. 8. A provision shall be made available to
3 35 policyholders, under group policies covering hospital,
4 1 medical, or surgical expenses for payment of necessary medical
4 2 or surgical care and treatment, as well as drug prescriptions,
4 3 provided by a person licensed to practice podiatry under
4 4 chapter 149, if the care and treatment are provided within the
4 5 scope of the person's license and if the policy would pay for
4 6 the care and treatment if the care and treatment were provided
4 7 by a person engaged in the practice of medicine and surgery as
4 8 licensed under chapter 148 or 150A. The provision shall also
4 9 guarantee that any medical or surgical services provided by a
4 10 podiatrist shall be compensated at the same level as
4 11 equivalent services provided by a person licensed in the
4 12 practice of medicine or surgery under chapter 148 or 150A.
4 13 The policy shall provide that the policyholder may reject the
4 14 coverage or provision if the coverage or provision for similar
4 15 services which may be provided by a podiatric physician is
4 16 rejected for all providers of services as licensed under
4 17 chapter 148, 149, or 150A. This subsection applies to group
4 18 policies delivered or issued for delivery on or after July 1,
4 19 2003, and to existing group policies on their next anniversary
4 20 or renewal date, or upon expiration of the applicable
4 21 collective bargaining contract, if any, whichever is later.
4 22 This subsection does not apply to blanket, short-term travel,
4 23 accident only, limited or specified disease, or individual or
4 24 group conversion policies, or policies designed only for
4 25 issuance to persons for coverage under Title XVIII of the
4 26 federal Social Security Act, or any other similar coverage
4 27 under a state or federal government plan.

4 28 Sec. 3. Section 509.3, unnumbered paragraph 1, Code 2003,
4 29 is amended to read as follows:

4 30 In addition to the provisions required in subsections 1
4 31 through 7 8, the commissioner shall require provisions through
4 32 the adoption of rules implementing the federal Health

4 33 Insurance Portability and Accountability Act, Pub. L. No. 104=
4 34 191.

4 35 Sec. 4. Section 514B.1, subsection 5, paragraphs b, c, and
5 1 d, Code 2003, are amended to read as follows:

5 2 b. The health care services available to enrollees under
5 3 prepaid group plans covering vision care services or
5 4 procedures, shall include a provision for payment of necessary
5 5 medical or surgical care and treatment provided by an
5 6 optometrist licensed under chapter 154, if performed within
5 7 the scope of the optometrist's license, and the plan would pay
5 8 for the care and treatment when the care and treatment were
5 9 provided by a person engaged in the practice of medicine or
5 10 surgery as licensed under chapter 148 or 150A. Additionally,
5 11 any optometric medical or surgical care and treatment provided
5 12 shall be compensated at the same level as equivalent services
5 13 provided by a person licensed in the practice of medicine or
5 14 surgery under chapter 148 or 150A. The plan shall provide
5 15 that the plan enrollees may reject the coverage for services
5 16 which may be provided by an optometrist if the coverage is
5 17 rejected for all providers of similar vision care services as
5 18 licensed under chapter 148, 150A, or 154. This paragraph
5 19 applies to services provided under plans made after July 1,
5 20 1983, and to existing group plans on their next anniversary or
5 21 renewal date, or upon the expiration of the applicable
5 22 collective bargaining contract, if any, whichever is the
5 23 later. This paragraph does not apply to enrollees eligible
5 24 for coverage under Title XVIII of the Social Security Act or
5 25 any other similar coverage under a state or federal government
5 26 plan.

5 27 c. The health care services available to enrollees under
5 28 prepaid group plans covering diagnosis and treatment of human
5 29 ailments, shall include a provision for payment of necessary
5 30 diagnosis or treatment provided by a chiropractor licensed
5 31 under chapter 151 if the diagnosis or treatment is provided
5 32 within the scope of the chiropractor's license and if the plan
5 33 would pay or reimburse for the diagnosis or treatment of human
5 34 ailment, irrespective of and disregarding variances in
5 35 terminology employed by the various licensed professions in
6 1 describing the human ailment or its diagnosis or its
6 2 treatment, if it were provided by a person licensed under
6 3 chapter 148, 150, or 150A. Additionally, any diagnosis and
6 4 treatment provided by a chiropractor shall be compensated at
6 5 the same level as equivalent services provided by a person
6 6 licensed in the practice of medicine or surgery under chapter
6 7 148 or 150A. The plan shall also provide that the plan

6 8 enrollees may reject the coverage for diagnosis or treatment
6 9 of a human ailment by a chiropractor if the coverage is
6 10 rejected for all providers of diagnosis or treatment for
6 11 similar human ailments licensed under chapter 148, 150, 150A,
6 12 or 151. A prepaid group plan of health care services may
6 13 limit or make optional the payment or reimbursement for lawful
6 14 diagnostic or treatment service by all licensees under
6 15 chapters 148, 150, 150A, and 151 on any rational basis which
6 16 is not solely related to the license under or the practices
6 17 authorized by chapter 151 or is not dependent upon a method of
6 18 classification, categorization, or description based upon
6 19 differences in terminology used by different licensees in
6 20 describing human ailments or their diagnosis or treatment.
6 21 This paragraph applies to services provided under plans made
6 22 after July 1, 1986, and to existing group plans on their next
6 23 anniversary or renewal date, or upon the expiration of the
6 24 applicable collective bargaining contract, if any, whichever
6 25 is the later. This paragraph does not apply to enrollees
6 26 eligible for coverage under Title XVIII of the Social Security
6 27 Act, or any other similar coverage under a state or federal
6 28 government plan.

6 29 d. The health care services available to enrollees under
6 30 prepaid group plans covering hospital, medical, or surgical
6 31 expenses, may include, at the option of the employer
6 32 purchaser, a provision for payment of covered services
6 33 determined to be medically necessary provided by a certified
6 34 registered nurse certified by a national certifying
6 35 organization, which organization shall be identified by the
7 1 Iowa board of nursing pursuant to rules adopted by the board,
7 2 if the services are within the practice of the profession of a
7 3 registered nurse as that practice is defined in section 152.1,
7 4 under terms and conditions agreed upon between the employer
7 5 purchaser and the health maintenance organization, subject to
7 6 utilization controls. Additionally, any covered services
7 7 provided by a registered nurse shall be compensated at the
7 8 same level as equivalent services provided by a person

7 9 licensed in the practice of medicine or surgery under chapter
7 10 148 or 150A. This paragraph shall not require payment for
7 11 nursing services provided by a certified registered nurse
7 12 practicing in a hospital, nursing facility, health care
7 13 institution, a physician's office, or other noninstitutional
7 14 setting if the certified registered nurse is an employee of
7 15 the hospital, nursing facility, health care institution,
7 16 physician, or other health care facility or health care
7 17 provider. This paragraph applies to services provided under
7 18 plans within this state made on or after July 1, 1989, and to
7 19 existing group plans on their next anniversary or renewal
7 20 date, or upon the expiration of the applicable collective
7 21 bargaining contract, if any, whichever is later. This
7 22 paragraph does not apply to enrollees eligible for coverage
7 23 under an individual contract or coverage designed only for
7 24 issuance to enrollees eligible for coverage under Title XVIII
7 25 of the federal Social Security Act, or under coverage which is
7 26 rated on a community basis, or any other similar coverage
7 27 under a state or federal government plan.

7 28 Sec. 5. Section 514B.1, subsection 5, Code 2003, is
7 29 amended by adding the following new paragraph:

7 30 NEW PARAGRAPH. e. The health care services available to
7 31 enrollees under prepaid group plans covering hospital,
7 32 medical, or surgical expenses shall include a provision for
7 33 payment of necessary medical or surgical care and treatment as
7 34 well as drug prescriptions provided by a podiatric physician
7 35 licensed under chapter 149, if performed within the scope of
8 1 the podiatrist's license and the plan would pay for the care
8 2 and treatment when the care and treatment were provided by a
8 3 person engaged in the practice of medicine or surgery as
8 4 licensed under chapter 148 or 150A. Additionally, any medical
8 5 or surgical service provided by a podiatrist shall be
8 6 compensated at the same level as equivalent services provided
8 7 by a person licensed in the practice of medicine or surgery
8 8 under chapter 148, 149, or 150A. The plan shall provide that
8 9 the plan enrollees may reject the coverage for services which
8 10 may be provided by a podiatric physician if the coverage is
8 11 rejected for all providers of similar services as licensed
8 12 under chapter 148, 149, or 150A. This paragraph applies to
8 13 services provided under plans made on or after July 1, 2003,
8 14 and to existing group plans on their next anniversary or
8 15 renewal date, or upon the expiration of the applicable
8 16 collective bargaining contract, if any, whichever is the
8 17 later. This paragraph does not apply to enrollees eligible
8 18 for coverage under Title XVIII of the federal Social Security
8 19 Act or any other similar coverage under a state or federal
8 20 government plan.

8 21 EXPLANATION

8 22 This bill establishes the requirement under group insurance
8 23 policies and health maintenance organization contracts that
8 24 treatment or services provided by a person licensed under Code
8 25 chapter 154 (optometrist), a person licensed under Code
8 26 chapter 151 (chiropractor), a person licensed under Code
8 27 chapter 152 (nursing), or a person licensed under Code chapter
8 28 149 (podiatrist), are to be compensated at the same level as
8 29 if the treatment or services were provided by a person
8 30 licensed under Code chapter 148 or 150A (allopathic and
8 31 osteopathic physicians).

8 32 The bill establishes provisions under group insurance
8 33 policies and health maintenance organization contracts to
8 34 require that if the policy or available health care services
8 35 currently cover or include care and treatment, as well as drug
9 1 prescriptions, if provided by a person licensed to practice
9 2 medicine and surgery under Code chapter 148 or a person
9 3 licensed to practice osteopathic medicine and surgery under
9 4 Code chapter 150A, the plan or health care services available
9 5 shall also allow for provision of the care and treatment, as
9 6 well as drug prescriptions, by a podiatric physician. The
9 7 bill also requires that the care or treatment be within the
9 8 scope of practice of the podiatric physician. This
9 9 requirement applies to policies delivered and issued and
9 10 services provided under plans on or after July 1, 2003, and to
9 11 existing plans on the latter of the anniversary, renewal, or
9 12 expiration of a collective bargaining contract.

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